North Dakota (N.D.) State Plan To Prevent and Manage Chronic Disease

2012 – 2017

Annual Progress Report

February 2014

NORTH DAKOTA
DEPARTMENT *of* HEALTH

Introduction

Chronic diseases are a major cause of disability and death in North Dakota, as well as in the United States. The seven leading causes of North Dakota deaths in 2012 were heart disease, cancer, stroke, Alzheimer's disease, chronic obstructive pulmonary disease (COPD), unintentional injury and diabetes. They account for approximately 70 percent of all deaths per year in North Dakota. The estimated cost to the North Dakota Medicaid and Medicare systems of five major chronic diseases (heart disease, diabetes, hypertension, cancer and stroke) was $110 million and $461 million, respectively, in 2010 (CDC Chronic Disease Cost Calculator, 2013). According to the 2010 U.S. Census, 15.3 percent of North Dakotans were older than age 65; by 2030, that is expected to increase to 25.1 percent. With North Dakota's aging population and the significant improvements in mortality and longevity, the cost associated with chronic disease will increase significantly if no changes are made. Loss of work productivity, decrease in quality of life and increased disability also may result.

The *North Dakota State Plan to Prevent and Manage Chronic Disease* was developed in 2012 in conjunction with chronic disease stakeholders and partners in North Dakota to address the many challenges that North Dakota faces in trying to prevent and control chronic diseases for its citizens. The plan focuses on collaborative activities that will accomplish specified goals, objectives, and strategies laid out in the plan.

This report addresses the progress completed thus far in implementing the state plan. The first section includes an Executive Summary of major accomplishments within the six Goal areas of the state plan. Following the Executive Summary is a detailed list of ALL of the state plan objectives, strategies, and activities and the major accomplishments that have been completed.

The North Dakota Department of Health acknowledges the contributions of all partners and state staff who worked hard to develop the state plan and who have made progress toward its implementation.

North Dakota
Chronic Disease State Plan
Progress Report

Executive Summary

Goal 1: SURVEILLANCE AND EVALUATION

Develop and maintain an accessible comprehensive chronic disease surveillance and evaluation system that includes the identification of disparities, supports comprehensive data analysis, results in strategic interpretation and dissemination of findings, addresses programmatic goals and objectives and is utilized for planning, implementing and evaluating chronic disease program activities.

Major Accomplishments

- During early 2013, a **coordinated chronic disease evaluation team** was formed to guide chronic disease surveillance and evaluation activities at the North Dakota Department of Health (NDDoH) and also lead the implementation of the state plan's Goal 1 surveillance and evaluation activities. This team meets monthly and includes several NDDoH chronic disease staff members who specialize in epidemiology and evaluation. Chronic disease partners interested in joining this team are welcome.

- Throughout 2013, the chronic disease evaluation team worked with NDDoH chronic disease staff to develop a set of extensive and prioritized **chronic disease indicators** to guide data analysis and report on chronic disease outcomes. In January 2014, this list was shared with chronic disease partners for comment.

- The NDDoH continues to **collect data** on an ongoing basis through various surveillance systems (e.g., Behavioral Risk Factor Surveillance System (BRFSS), Adult and Youth Tobacco Surveys, Youth Risk Behavior Survey (YRBS)) and accommodates data requests within three business days. **Data gaps** are identified regularly through the NDDoH chronic disease epidemiologist's work with the Healthy People 2020 workgroup and the NDDoH epidemiology workgroup.

- Gaining **access to data about Native Americans and older adults** continues to be a high priority. An epidemiologist specializing in Native American data was recently hired at NDSU as part of the MPH program to work on Native American data and partner with each tribe in North Dakota. Access to Medicare data is available through existing reports, such as CDC's Morbidity and Mortality Weekly Report.

- The **Chronic Disease Status Report** for 2012 was released in early March 2013. This report was shared with the North Dakota Legislature during crossover of the 2013 Legislative Session, as well as with partners. Hard copies are available, and a link to the report is available on the Division of Chronic Disease website. The next Status Report will be ready for release in March 2015, and will include all of the chronic disease indicators compiled by the chronic disease evaluation team.

- The NDDoH Tobacco Prevention and Control Program continues to regularly develop and update **fact sheets** for use by partners.

Goal 2: ENVIRONMENTAL APPROACHES THAT PROMOTE HEALTH AND SUPPORT AND REINFORCE HEALTHFUL BEHAVIORS

Change policies and environments to enhance personal health behaviors such as physical activity, healthy eating and tobacco-free living.

Major Accomplishments

- A **survey of chronic disease partners** was conducted to identify program and policy priority areas and legislative priorities. A draft list of priority strategies has been developed for state and local partners to select from as each of them develops their internal priorities. A draft of a **short/long-term policy agenda** is in the beginning stages.
- Work toward **tobacco policy changes** included:
    - The citizens of North Dakota passed a comprehensive smoke-free law in November 2012 that includes **all indoor public places and workplaces.**
    - As of December 2013, around 60 percent of **school districts** have adopted comprehensive tobacco-free policies.
    - **Tobacco cessation counseling and education** from health-care providers is being completed at all tertiary hospitals in North Dakota through the Million Hearts S grants.
- Efforts toward **education that may potentially result in policy changes** include:
    - Dissemination of the 2012 Chronic Disease Status Report to legislators.
    - National walkability expert Mark Fenton spoke about community walkability to 160 participants at the 2013 Chronic Disease Conference.
    - Training on Using Policy Analysis Tools was held at the Shaping Policy for Health meeting in Fargo and Bismarck at no cost to participants.
    - Two *Be Fit 2 Learn* trainings specifically targeted to North Dakota classroom teachers were held to teach them new methods of incorporating physical activity in the classroom.
    - NDDoH sent out a news release during Diabetes Awareness month regarding healthy beverage behaviors.
- Best Practices for Physical Activity in **Child Care** and Best Practices for Nutrition in **Child Care** have been developed and disseminated to child care providers statewide and are used with the NDDHS Early Learning Guidelines to assist in defining state regulations.
- Work toward **enhancing local capacity** to implement policy and environmental change occurred through 1) Each Local Public Health Unit completing a community needs assessment, and 2) Technical assistance provided to local communities as they determine priorities for health improvement.
- Efforts toward **worksite wellness** include:
    - The Healthy ND Worksite Wellness program established relationships with state chronic disease programs to develop and promote strategies for increased physical activity in North Dakota worksites.
    - Funding was secured by NDDoH for three community projects that establish or enhance local worksite wellness programs.

- The NDDoH Community Health Section Wellness Committee hosted several events to increase physical activity among staff.

- Efforts toward **breastfeeding policies** include:
  - The North Dakota Infant-Friendly Worksite Designation Program continues to be supported by NDDoH, allowing ongoing promotion and technical assistance for worksite breastfeeding policies.
  - The North Dakota Breastfeeding Coalition promotes and supports educational efforts statewide and provides technical assistance to partners on worksite breastfeeding policies. As of December 2013, 47 N.D. worksites, representing over 12,000 employees, have been designated as "infant-friendly," indicating the presence of a worksite policy with identified criteria supporting breastfeeding.
  - The North Dakota Comprehensive Cancer Prevention and Control Program supported a local sub-contract project to provide technical assistance for the promotion and development of workplace policies that support breastfeeding.

Goal 3: HEALTH-CARE SYSTEMS AND QUALITY IMPROVEMENT (HEALTH SYSTEMS INTERVENTIONS)

Expand access to and utilization of coordinated, proactive and quality health-care services.

Major Accomplishments

- Support for adoption of quality improvement chronic disease models of care has occurred through the partnership between NDDoH and Blue Cross Blue Shield of ND (BCBSND) through continued implementation of BCBSND's **MediQHome Quality Program (MQP). MQP** is a statewide program designed to transform primary care in N.D. MQP combines principles of the patient-centered medical home with technology tools, and allows clinicians to focus on patients' health outcomes through the use of an interactive decision support tool, MDinsight (MDI). MDI is a free, web-based decision support tool that identifies care opportunities by organizing all available patient clinical data to create clinical summaries and quality reports specific to each patient. Information about care opportunities is stored in one place and is easily accessible to the clinicians at the point of care. Having this information allows clinicians to identify current and missed care opportunities in individual patients or groups of patients with specific chronic conditions. Of the 27 clinics currently contracted to participate in MQP, 23 of them are either fully implemented or in the process of implementation. These 23 clinics account for 76 percent of the state's participating BCBSND providers. Currently, 85 percent of BCBSND's members have been attributed to a medical home.
- The NDDoH Chronic Disease Division is partnering with the EMS Division regarding a pilot project through **Community Paramedic**, a program that utilizes already existing EMS and/or paramedics to fill identified health-care gaps within communities. An initial stakeholder meeting has been held and two more stakeholder meetings are scheduled for spring 2014. Currently, models of reimbursement from other states are being studied.
- The NDDoH **Tobacco Prevention and Control Program** has done the following:
    - Family Planning Programs and Safety Net Dental Clinics are working on incorporating Public Health Service Guidelines for Tobacco (Ask, Advise, Refer) into electronic medical records. Through the Million Hearts S grants, hospitals statewide are developing and expanding tobacco cessation centers and institutionalizing Ask, Advice, Refer into their health systems and electronic medical records.
    - Met with Medicaid staff to encourage Medicaid coverage for in-person cessation counseling.
    - Offered two webinars (and CMEs) to health-care providers across the state on treating tobacco use and implementation of the Public Health Service guidelines.
    - The Baby & Me – Tobacco Free program was expanded to seven sites across the state, including the first hospital to offer the program.

- Working together, the North Dakota Comprehensive Cancer Prevention and Control Program and the North Dakota Cancer Coalition developed a **skin cancer education toolkit** for distribution across the state.
- The toolkit contains information about ultraviolet protection, including the risk of tanning bed use, and has ready-to-use activities and lesson plans for all age groups in a variety of settings.
- The Stroke System of Care Task Force has begun discussing the use of **telehealth** in Critical Access Hospitals for **stroke patients**.
- NDDoH provided funding for the Diabetes Training and Technical Assistance Center (DTTAC) to hold training sessions at six sites across North Dakota on the evidence-based **National Diabetes Prevention Program**.

GOAL 4: PERSONAL HEALTH AND SELF-MANAGEMENT (COMMUNITY-CLINICAL LINKAGES)

Support engagement of individuals in their efforts to reach optimal health.

- The **NDDoH Tobacco Prevention and Control Program** has been involved in the following efforts:
  - Developed a weatherproof sticker advertising NDQuits that can be placed on cigarette receptacles in public areas and distributed these to several communities.
  - Educated several high-risk populations, including Lesbian Gay Bisexual Transgender (LGBT), oil workers, and several community organizations who serve lower socioeconomic status (SES) populations about the NDQuits program.
  - Promoted the availability of nicotine replacement therapy through the NDQuits program to those uninsured or underinsured in North Dakota who use NDQuits.
  - Provided information about the cost of tobacco to employers at the Healthy ND Worksite Wellness Summit, along with a calculator to calculate the loss to their business because of tobacco use.
  - Partnered with North Dakota Medicaid regarding cessation medication available to the Medicaid population. Medication availability is promoted through print media, radio, newspaper, TV and digital advertising.

- The NDSU pharmacy school partnered with the American Heart Association and NDDoH heart disease and stroke staff to discuss **pharmacists assisting with the use of blood pressure control** to help improve health outcomes.

- NDDoH **diabetes** staff provided technical assistance and materials to sites offering the National Diabetes Prevention Program.

GOAL 5: HEALTH INEQUITIES

Address health inequities in planning for the improvement of population health.

The NDDoH **Tobacco Prevention and Control Program** has accomplished the following:

- Worked with the Northern Plains Tribal Tobacco Technical Assistance Center to provide training on brief interventions to address tobacco use through the tribal Community Health Representatives. This training was offered at all four North Dakota reservations.
- Worked toward smoke-free policy changes specifically targeted for LGBT and American Indian populations.
- Worked with Migrant Health staff to revise NDQuits Spanish materials.

The **NDDoH Cancer Program** collaborated with Tribal Health staff from the Fort Berthold reservation and nursing students from the Fort Berthold Community College to host a bone marrow donor drive that registered 13 new American Indian donors on the National Marrow Donor Registry.

GOAL 6: CAPACITY

Develop capacity (including leadership, management, training, resources and partnerships) to advance chronic disease prevention and health promotion in North Dakota.

- Currently there are about 50 partners involved in the Coordinated Chronic Disease Partnership.

- The NDDoH continues to have an internal team called the **Chronic Disease Coordination Team (CDCT)** that consists of various NDDoH program staff, evaluators and an epidemiologist who work on chronic disease prevention and control activities. This group meets monthly to discuss opportunities for collaborating on NDDoH chronic disease projects, as well as to implement the chronic disease state plan in conjunction with the Coordinated Chronic Disease Partnership.

- NDDoH chronic disease staff members have been working to **integrate the chronic disease state plan with other state plans**, such as the MCH-Title V state plan.

- On May 20-21, 2013, NDDoH held its first **Chronic Disease State Conference** titled "Working Together: Preventing and Managing Chronic Disease in North Dakota," which brought together 160 health professionals from across the state.

- During the 2013 Legislative Session, additional dollars for the Stroke System of Care were secured. The tobacco prevention and control funding was left intact.

- NDDoH developed a **chronic disease communication plan** in December 2013 in a calendar format that includes health awareness days/weeks/months. The communication calendar will be used as a tool for coordinating chronic disease communications and cross-promotion of programs and risk factors through press releases, social media, etc.

North Dakota Chronic Disease State Plan Progress Report

Goals, Objectives, Strategies, Activities and Specific Progress

SURVEILLANCE AND EVALUATION

GOAL 1: Develop and maintain an accessible, comprehensive chronic disease surveillance and evaluation system that includes the identification of disparities, supports comprehensive data analysis, results in strategic interpretation and dissemination of findings, addresses programmatic goals and objectives, and is utilized for planning, implementing and evaluating chronic disease program activities.

Short Term Objectives:

By 2014, obtain data from at least one new data source to monitor the burden of chronic disease in North Dakota.

By 2014, develop and distribute at least two chronic disease surveillance and evaluation data reports, ensuring they are accessible to all users.

By 2014, implement at least seven chronic disease program activities (by the state health department and/or partners) using surveillance and evaluation data to guide program planning and implementation.

Strategies:

1.1 Maintain chronic disease surveillance and evaluation system.

Integration Activities:

1.1.1 Develop a sub-committee to provide guidance for further defining and monitoring the chronic disease surveillance and evaluation system.
During early 2013, a coordinated chronic disease evaluation team was formed to guide chronic disease surveillance and evaluation activities at the NDDoH and also to lead the implementation of the state plan's Goal 1 surveillance and evaluation activities. This team meets monthly and consists of several NDDoH chronic disease staff, including those dedicated to epidemiology and evaluation.

1.1.2 Develop a set of chronic disease surveillance and evaluation indicators to be used for measuring chronic disease prevention and management outcomes.
Throughout 2013, the chronic disease evaluation team worked with NDDoH chronic disease staff to develop a set of extensive and prioritized chronic disease indicators to guide data analysis and reporting on chronic disease outcomes. In January 2014, this list was shared with chronic disease partners for comment.

1.1.2a Create a surveillance plan which includes the sources of data, what will be collected and the frequency.

1.1.2b Collect information on an ongoing basis.
Information is collected on an ongoing basis through BRFSS, Adult and Youth Tobacco Surveys, YRBS and various other surveillance systems.

1.1.2c Identify data gaps on an ongoing basis.
Data gaps are identified regularly through the NDDoH chronic disease

epidemiologist's work with the Healthy People 2020 and NDDoH epidemiology workgroup.

1.1.2d Disseminate data as scheduled and as available or as requested, including publications of audience-specific reports.

- Data requests are accommodated by NDDoH within three business days.
- The Chronic Disease Status Report for 2012 was released in early March 2013. This report was shared with the Legislative Body during crossover of the 2013 Legislative Session, as well as with partners. Hard copies are available, and a link to the report is also on the Chronic Disease website.

1.1.3 Maintain quality of life questions in population-based surveys of health status.
Quality of life questions are maintained by the NDDoH epidemiologist.

1.1.4 Maintain and disseminate the chronic disease burden report.
The next Chronic Disease Status Report will be ready for release in March 2015, and will include all of the chronic disease indicators compiled by the chronic disease evaluation team.

1.1.5 Continue involvement with Healthy People 2020, including but not limited to, tracking selected outcome and disseminating reports.
The NDDoH chronic disease epidemiologist continues to be involved in the Healthy People 2020 workgroup.

1.1.6 Explore expansion of access to data sources, including hospital discharge data sharing.

1.1.6a Work with local tribes to develop a data-sharing agreement between tribes and the NDDoH that will provide access to tribal specific chronic disease data.
An epidemiologist was recently hired at NDSU as part of the Masters in Public Health program to work on Native American data and partner with each tribe in North Dakota.

1.1.6b Obtain Medicare chronic disease(s) data.
Although Medicare data from CMS is available, at this time there is no expertise in NDDoH to analyze this data. However, North Dakota Medicare information that is available through other sources (e.g. MMWR, etc.) is gathered.

1.1.7 Ensure chronic disease data is accessible and user friendly for people to plan programs, make decisions and evaluate progress.

1.1.7a Develop a comprehensive data communication plan.

1.1.7b Provide resources about how to use data to the best advantage.

1.1.8 Develop and disseminate a chronic disease evaluation report documenting major outcomes from the NDDoH chronic disease and risk factor-related programs, as well as their partners, including a section on Coordinated Chronic Disease State Plan progress.

1.1.8a Develop a plan for dissemination of surveillance and evaluation regarding the individual categorical plan priorities.

1.1.8b Complete annual reports, including surveillance and evaluation information.

1.1.8c Evaluate the success of dissemination activities.

1.1.8d Utilize findings to guide future decision making.

1.1.9 Based on available data, develop a chronic disease data report organized by the social determinants of health.
The next North Dakota Chronic Disease Status Report, scheduled for March 2015 release, will incorporate social determinants of health.

1.1.9a Support community-based participatory research for populations that experience challenges with health equity by involving the communities impacted by chronic disease inequities in the planning, implementation, analysis and dissemination of chronic disease research.

1.1.9b Utilize reports regarding health disparities between people with and without disabilities.

1.2 Encourage partners to use a standard, validated method for assessment of chronic disease prevention and management.

Integration Activities:

1.2.1 Develop materials for use by partners that describe specific outcome measures aligned with categorical program goals (per state plans).
The NDDoH Tobacco Prevention and Control Program continues to regularly develop and update fact sheets for use by partners.

1.2.2 Identify a framework for assessment of chronic disease prevention and management effectiveness at program, community, region and state levels.

1.2.3 Provide technical assistance services and educational opportunities to support evaluation of community-based and state-level projects for chronic disease prevention and management.

ENVIRONMENTAL APPROACHES THAT PROMOTE HEALTH AND SUPPORT AND REINFORCE HEALTHFUL BEHAVIORS

GOAL 2: Change policies and environments to enhance personal health behaviors, such as physical activity, healthy eating and tobacco-free living.

<u>Short Term Objective:</u> By 2014, begin implementation toward at least 10 policy and environmental changes that will support healthy behaviors for the people of North Dakota.

Strategies:
2.1 Advocate for environmental and policy changes at state and local levels.

Integration Activities:

2.1.1 Identify policies at the state and community levels (including schools, worksites, child- and adult-care programs, transportation, and agricultural and health-care settings) that are facilitators and/or barriers to physical activity, healthy eating and tobacco-free living.

- The citizens of North Dakota passed a comprehensive smoke-free law in November 2012 that includes all indoor public places and workplaces.
- As of December 2013, around 60 percent of school districts have adopted comprehensive tobacco-free policies.
- As of December 2013, 47 North Dakota worksites, representing a total of over 12,000 employees, have been designated as "infant-friendly" indicating the presence of a worksite policy with identified criteria supporting breastfeeding.

2.1.2 Explore leveraging categorical program advisory boards/committees for policy development, advocacy responsibilities and other resources.

2.1.3 Develop and implement a policy and environmental change plan with strategies that support health and personal health behaviors at the state, community and organizational levels.

2.1.3a Consider developing a short-term and long-term policy agenda within the policy plan.
A survey of chronic disease partners was conducted to identify program and policy priority areas and legislative priorities. A draft list of priority strategies has been developed for state and local partners to select from as each of them develops their internal priorities. A draft of a short/long-term policy agenda is in the beginning stages.

2.1.3b Partner to increase opportunities for physical activity in general by working with communities on making the environment more accessible through walking, biking, and other traditional modes of transportation.
A national walkability expert, Mark Fenton, presented a keynote and a breakout session at the 2013 Chronic Disease Conference, reaching 160 participants and increasing their understanding of community walkability.

2.1.3c Promote 30 minutes a day of physical activity for K-12 students.
Two *Be Fit 2 Learn* trainings were held in North Dakota specifically targeted to classroom teachers to instruct them on new methods of how to incorporate physical activity in the classroom.

2.1.3d Promote school nurse coverage in all schools.

2.1.3e Promote the elimination of nonsmokers' exposure to secondhand smoke.
The citizens of North Dakota passed a comprehensive smoke-free law in November 2012 that includes all indoor public places and workplaces.

2.1.3f Promote the adoption of evidence-based or best practice worksite interventions (including sample policies) that address the inclusion of physical activity as part of the workday.
The Healthy ND Worksite Wellness program has established relationships with state chronic disease programs to develop and promote strategies for increased physical activity in worksites.

2.1.3g Promote healthy food and beverage choices for cafeterias, events and vending machines in various settings, such as work sites, schools and community gathering places.
Success stories and resources from local communities are being shared at statewide conferences, on websites and in newsletters.

2.1.3h Promote regular physical activity and tobacco cessation through counseling and education from health-care providers and organizations.
Tobacco cessation counseling and education from healthcare providers is being completed at all ND tertiary hospitals through Million Hearts S grants.

2.2 Educate decision makers and the public regarding the effects of policies and environmental factors on personal health behaviors, morbidity and societal costs.

Integration Activities:

2.2.1 Develop consistent and constructive messaging about environmental factors on personal health behaviors, morbidity and societal costs.
NDDoH sent out a news release during Diabetes Awareness Month regarding healthy beverage behaviors.

2.2.2 Unify communication with stakeholders to coordinate consistent and constructive messaging about policies and environmental factors on personal health behaviors, morbidity and societal costs.

2.2.2a Educate legislators about the impact of chronic disease in N.D. and their role in preventing and controlling chronic disease, and identify and cultivate champions for chronic disease advocacy within the North Dakota legislature.
Education has taken place through the development and dissemination of the 2012 Chronic Disease Status Report.

2.2.2b Develop fact sheets highlighting the human and economic costs of chronic disease in North Dakota and the cost benefits of chronic disease prevention and care.

2.2.2c Educate policymakers about chronic disease and its complications through personal stories, dissemination of materials, and forums that enable people with chronic disease to testify.

2.2.2d Utilize social marketing and a deliberate media plan to increase key public health messages about arthritis to increase the public's recognition that arthritis is a serious chronic condition.

2.2.2e Pursue a variety of methods (e.g., direct mail, website, webcasts, newsletter, publications, presentations, etc.) to inform health-care professionals about current research and resources available in the community for persons with chronic disease.

2.2.3 Develop a mechanism to facilitate regular communication between stakeholders, including the Community Transformation Grant (CTG) recipients, to maximize activities and minimize duplication of efforts.
The NDDoH Chronic Disease Director is part of the CTG Leadership Team. To assist with the duplication of efforts, the 2012 Chronic Disease Status report was shared and utilized to assist with meeting the needs of CTG activities.

2.3 Enhance local capacity to assist with developing and/or leveraging policy and environmental change as a means to improve indicators of community health.

Integration Activities:

2.3.1 Assist communities in determining their chronic disease priorities through community engagement processes.
- Each Local Public Health Unit has completed a community needs assessment, which will assist with determining their chronic disease priorities.
- Technical assistance is provided to local communities as they determine priorities for health improvement.

2.3.2 Identify local community stakeholders and champions.

2.3.3 Leverage community, state and federal resources.

2.3.4 Provide technical assistance and educational activities that develop and implement policy and environmental change for personal health behaviors.
Technical Assistance is provided through a variety of programs within NDDoH, including cancer, tobacco, diabetes, obesity prevention and school health.

2.3.4a Develop or identify and implement a training curriculum that helps community leaders understand what environmental and policy change is, why it's important and how to implement it within sectors of the community.
NDDoH contracted with DHPE (Directors of Health Promotion Educators) to bring Module 2 (Using Policy Analysis Tools) of the Shaping Policy for Health

training into the state at no cost to the participants. Training sessions were held in Fargo in October and in Bismarck in November, 2013.

2.3.4b Healthy Eating

2.3.4ba Advocate for local and state policies to improve access and intake of healthy foods.

2.3.4bb Promote access to healthy foods in the worksite.

2.3.4bc Promote access to healthy foods in school settings.

2.3.4bd Promote implementation of culturally-appropriate nutrition programs, practices and policies.

2.3.4be Partner with existing coalitions, such as the Healthy Eating and Physical Activity Partnership, to increase access to and consumption of more fruits and vegetables, particularly among the underserved populations.

2.3.4c Physical Activity

2.3.4ca Advocate for local and state policies to increase physical activity in schools.

2.3.4cb Advocate for statewide physical activity policies in child-care settings.
Best Practices for Physical Activity in Child Care have been developed and disseminated to child-care providers statewide and are used with the NDDHS Early Learning Guidelines to assist in defining state regulations.

2.3.4cc Advocate for local policies and practices designed to provide opportunities to support and help people be more physically active in their communities.

2.3.4cd Conduct community-wide campaigns to increase access to physical activity opportunities.

2.3.4ce Promote implementation of culturally-appropriate physical activity programs, practices and policies.

2.3.4d Worksite Wellness

2.3.4da Support physical activity programs sponsored by *Healthy ND* and other worksite wellness initiatives.
The Healthy ND Worksite Wellness program has established relationships with state chronic disease programs to develop and promote strategies for increased physical activity in North Dakota worksites.

2.3.4db Support onsite physical activity programs in the workplace, or increase access to physical activity sites for workers.

- Funding was secured by NDDoH for three community projects that establish or enhance local worksite wellness programs.
- The NDDoH Community Health Section Wellness Committee hosted several events to increase physical activity among staff.

2.3.4e Support legislative capacity to include chronic disease services and prevention measures through public policy for populations who experience inequity in chronic disease care.

2.3.4f Support education and training that promotes breastfeeding policies in the workplace.

- The North Dakota Infant-Friendly Worksite Designation Program continues to be supported by NDDoH, allowing ongoing promotion and technical assistance of worksite breastfeeding policies.
- The North Dakota Breastfeeding Coalition promotes and supports education efforts statewide.
- The North Dakota Comprehensive Cancer Prevention and Control Program supported a local sub-contract project to provide technical assistance for the promotion and development of workplace policies that support breastfeeding.

2.3.4g Support partner efforts to advocate for breastfeeding policies in the workplace.

NDDoH and the North Dakota Breastfeeding Coalition provide technical assistance to partners on worksite breastfeeding policies.

2.3.4h Encourage schools to include in their curriculum basic skills for cooking healthy meals.

2.4 Develop a mechanism for local stakeholders to exchange the successes and lessons learned for policies that support personal health behaviors.

2.4.1 Develop and disseminate media materials such as news releases, fact sheets, personal stories, media advisories and news conference kits.

HEALTH-CARE SYSTEMS AND QUALITY IMPROVEMENT (HEALTH SYSTEMS INTERVENTIONS)

GOAL 3: Expand access to and utilization of coordinated, proactive and quality health-care services.

Short Term Objective: ***By 2014, at least five new health-care providers/organizations will begin implementing quality improvement chronic disease models of care.***

Strategies:

3.1 Advocate for the adoption of quality improvement chronic disease models of care to advance consistent delivery of high quality care.

Integration Activities:

3.1.1 Advocate for and/or support quality improvement projects for accelerating adoption of medical practice models that consistently deliver high-quality chronic disease care, such as patient-centered medical home.
Support for adoption of quality improvement chronic disease models of care has occurred through the partnership between NDDoH and Blue Cross Blue Shield of ND (BCBSND) in continued implementation of BCBSND's MediQHome Quality Program (MQP), a statewide program designed to transform primary care in North Dakota. Details about this program are provided in the Executive Summary.

3.1.2 Provide technical and/or financial support to establish systems to enhance chronic disease models of care. These systems could include clinical information, patient management, electronic health records, use of decision support tools and protocols, and/or feedback on provider performance.
NDDoH provides financial support for implementation of MQP through BCBSND.

3.1.3 Advocate for use of incentives for health-care providers to adopt chronic disease models of care.

3.1.4 Promote adoption of an interdisciplinary, team-based approach, including patient and family members, to support chronic disease care.
The NDDoH Chronic Disease Division is partnering with the EMS Division regarding a pilot project in relation to Community Paramedic, a program that utilizes already existing EMS and/or paramedics within the community to fill identified health-care gaps within communities.

3.1.5 Advance use of electronic health records that incorporate algorithms to encourage provider adherence to current prevention and treatment guidelines for chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis.
Family Planning Programs and Safety Net Dental Clinics are working on incorporating Public Health Service Guidelines for Tobacco (Ask, Advise, Refer) into electronic medical records. Through the Million Hearts S grants, hospitals statewide are

developing and expanding tobacco cessation centers and institutionalizing "Ask, Advise, Refer" into their health systems and electronic medical records.

3.1.6 Provide leadership and/or collaborate on systems change interventions, including clinical data exchanges, that support adherence to evidence-based guidelines for screening, treating and managing chronic disease along with tobacco cessation (ask, advise, refer).

- Family Planning Programs and Safety Net Dental Clinics are working on incorporating Public Health Service Guidelines for Tobacco (Ask, Advise, Refer) into electronic medical records.
- All local public health units are implementing the Public Health Service Guidelines for Ask, Advise, Refer.

3.1.6a Promote the North Dakota Tobacco Prevention and Control Program's NDQuits cessation services.
The Baby & Me – This tobacco-free program was expanded to seven sites across the state, including to the first hospital to offer the program.

3.1.6b Promote insurance coverage for tobacco cessation services.
NDDoH Tobacco Prevention and Control Program staff met with staff from Medicaid to encourage their program to provide coverage for in-person cessation counseling.

3.1.6c Promote health-care provider training on Public Health Service Guidelines for Treating Tobacco Use and Dependence.
NDDoH Tobacco Prevention and Control Program offered two webinars (and CMEs) to health-care providers across the state on treating tobacco use and implementation of the PHS guidelines.

3.1.6d Promote health-care systems change by institutionalizing Public Health Service Guidelines.

3.1.6e Promote the use of quality and performance indicators in the delivery of quality care.

3.1.7 Convene and assist health-care providers in identifying actions to improve coordination and quality of care and facilitate systems change.

3.1.8 Encourage insurance purchasers and/or health plans to provide incentives for health-care providers to report and improve the proportion of patients achieving clinical standards for chronic disease management.

3.2 Provide information and technical support to health-care providers/organizations about national standards for prevention, services, and benefits of chronic disease care models.

Integration Activities:

3.2.1 Employ interactive website to assist public with selection of appropriate screening services, organized by gender and age.

3.2.2 Make available resources that address billing and reimbursement issues related to provision of preventive services.

3.2.3 Coordinate consistent and constructive messaging about prevention, services, and chronic disease care models.

3.2.3a Encourage health insurance companies to increase communication on covered services in terms lay people understand.

3.2.3b Promote informed and/or shared decision making based on personal and family history, age and health-care providers.

3.2.3c Reduce barriers to screening(s), including, but not limited to, language, financial, geographical, access and low literacy.

3.2.3d Promote chronic disease screening education using a multi-component approach, including small media and one-to-one education.
Working together, the North Dakota Comprehensive Cancer Prevention and Control Program and the North Dakota Cancer Coalition developed a skin cancer education toolkit for disbursement across the state. The toolkit contains information about ultraviolet protection, including the risk of tanning bed use, and has ready-to-use activities and lesson plans for all age groups in a variety of settings.

3.2.4 Provide and/or promote training on implementing evidence-based tools and guidelines and creating systems to deliver appropriate preventive care, detection and treatment for chronic diseases, such as heart disease, cancer, stroke, diabetes and arthritis.
NDDoH provided funding for the Diabetes Training and Technical Assistance Center (DTTAC) to provide training at six sites across North Dakota on the evidence-based National Diabetes Prevention Program.

3.2.4a Provide leadership and collaborate on systems change interventions that support adherence to established guidelines and recommendations.

3.2.4b Encourage use of telehealth and telemedicine options, especially for rural areas, for the elderly and long-term care facilities.
The Stroke System of Care Task Force has begun discussing the use of telehealth in Critical Access Hospitals for stroke patients.

3.2.4c Support health-care professional education that promotes shared decision making regarding treatment options.

3.2.4d Develop additional methods and channels for training to increase the number of group leaders available for self-help programs.

3.2.4e Support health-care provider education about the importance of obtaining detailed personal and family history identifying risk factors (inherited predisposition for chronic disease) that can initiate appropriate chronic disease screening.

3.2.5 Link innovative academic programs with community-based providers to support implementation of interdisciplinary, team-based models of chronic disease management.

3.2.5a Encourage the "one-stop shop concept" to make screening(s) more convenient.

3.2.5b Promote health-care providers' utilization of client reminders for screening(s). The BCBSND MediQHome Quality Program provides a platform for providers to track important regular clinical tests and easily reach out to patients to remind them they are due. The MDInsight tool keeps track of all of the information. A provider can utilize it for just one patient, or can run a search for a certain type of patient and send reminder letters based on the criteria.

3.2.5c Promote the business case to business leaders about the benefits of screening(s) and early detection, along with effective employer strategies to facilitate screening(s).

3.2.6 Link health-care providers and allied health workers to continuing education activities such as health literacy, cultural competency and community health workers.

3.2.6a Design strategies and incentives to help more health-care professionals pursue Certified Diabetes Educator credentials and/or continuing education, including other provider recognitions, especially in underserved areas.

3.2.6b Advocate for health-care workers to be trained in active listening and cultural sensitivity to optimally care for patients of different cultures and backgrounds.

3.2.6c Identify and work to eliminate obstacles for health systems tracking and evaluating quality improvement initiatives.

PERSONAL HEALTH AND SELF-MANAGEMENT (COMMUNITY-CLINICAL LINKAGES)

Goal 4: Support engagement of individuals in their efforts to reach optimal health.

Short Term Objectives:

By 2014, reach at least 10 percent of the population of North Dakota with messages and resources that will encourage their personal health and prevent chronic disease.

By 2014, increase the capacity of at least five health-care providers/organizations to reach their populations with personal health and self-management health messages, resources and services.

Strategies:

4.1 Develop and implement communication strategies reaching the continuum of life, to engage individuals in prevention and personal health behaviors.

Integration Activities:

4.1.1 Implement strategies that connect individuals with shared interests in personal health improvement.

4.1.2 Work with a variety of entities, including, but not limited to, school settings, worksites, child-care settings, and community and faith-based organizations to develop messaging to activate prevention behaviors such as getting blood pressure checks, utilizing NDQuits programs, and injury prevention utilizing appropriate messaging based on the audience.
The NDQuits program has been involved in various settings, such as the PRIDE event in Fargo, the Bakken Expo in Minot, etc. to engage the populations with a higher usage of tobacco and educate them about the NDQuits program.

4.1.3 Educate public on the features and benefits of prevention, personal health behaviors, self-management and education services as a means to increase utilization for services.

4.1.3a Use the Weight of the Nation conference materials and HBO series resources to increase the awareness of nutrition and physical activity as it relates to chronic disease.

4.1.3b Educate faith organization leaders, parish nurses and/or volunteers about the role faith organizations can play in encouraging health promotion and the prevention and control of chronic disease (e.g., letter about taking care of your body, sermons, etc.).

4.1.3c Educate community organizational leaders about the role they can play in encouraging health promotion and the prevention and control of chronic disease (e.g., in newsletters, letters from leaders about taking care of your body).

NDDoH Tobacco Prevention and Control Program reached out to several community organizations who serve lower SES populations to inform them of NDQuits services and to encourage them to refer their clients who use tobacco.

4.1.3d Engage physicians in providing information to their patients about prevention through healthy behavior choices and control through self-management strategies.

4.1.3e Educate the general public, policymakers and business leaders about the ongoing needs of survivors (i.e., stroke, cancer, heart disease).

4.1.3f Identify, develop and maintain accessible chronic disease survivorship resources.

4.1.3g Use target communications through a variety of channels that reach those at high risk to increase awareness and provide referral to available programs.

- NDDoH Tobacco Prevention and Control Program developed a weatherproof sticker advertising NDQuits that can be placed on cigarette receptacles in public areas and distributed them to several communities.
- Along with the North Dakota Campus Tobacco Prevention Project, NDDoH developed and distributed window clings, palm cards and posters to college campuses, promoting tobacco-free policies/grounds and help with quitting using NDQuits.

4.2 Provide trainings/resources for health care providers and other organizations to increase the utilization of services for all individuals including those with chronic disease, to receive regular prevention, personal health behavior, self-management and education services.

Integration Activities:

4.2.1 Raise employer and health plan awareness of benefit design factors (i.e., coverage) related to self-management, personal health behaviors and education services. Information about the costs of tobacco to employers was provided at the Healthy ND Worksite Wellness Summit, along with a calculator that helped employers calculate the amount their business is losing because of tobacco use.

4.2.2 Explore the resources that address billing and reimbursement issues related to provision of self-management, preventative screening and education services in clinical and community settings.

4.2.3 Work with health-care providers, employers, community and faith-based organizations and insurance companies to offer incentives for individuals to seek appropriate screening and preventive services.

4.2.4 Promote availability of no- or low-cost cessation medication.

- The NDQuits program provides a free two-months' supply of Nicotine Replacement Therapy to un- or under-insured North Dakota citizens who utilize NDQuits services.

- A partnership with ND Medicaid regarding cessation medication is available to the Medicaid population. The availability of the medications is promoted through print media, radio, newspaper, TV and digital advertising.

4.2.5 Connect individuals to prevention, self-management and education services.
NDDoH diabetes staff provided technical assistance and materials to sites offering the National Diabetes Prevention Program.

4.2.5a Work with local partners to offer Stanford's Chronic Disease Self-Management Program.

4.2.5b Ensure needs for children with chronic disease are met appropriately in schools.

4.2.5c Promote disease self-management training that is accessible, as well as culturally, individually and family-appropriate.

4.2.6 Train health-care providers to assess prevention and self-management behaviors as part of routine clinical encounters, as well as to assist with goal setting for personal health behaviors.

4.2.6a Encourage providers to screen chronic disease patients for depression and follow up/link to needed resources based on screening results.

4.2.6b Promote a comprehensive clinical approach to smoking cessation that includes screening for tobacco use, cessation counseling and pharmacotherapy.

4.2.6c Promote referrals to NDQuits and other community resources for comprehensive cessation counseling.

4.2.7 Study reimbursement barriers and opportunities for health-care providers to facilitate goal setting and follow up with patients.

4.2.7a Promote access to cessation products by reducing or eliminating co-pays or deductibles.

4.2.7b Promote reimbursement for self-management support provided by pharmacists, Community Health Workers (CHWs), Community Paramedic and other health extenders.
The NDDoH Division of Chronic Disease is partnering with the EMS Division regarding a pilot project in relation to Community Paramedic, a program that utilizes already existing EMS and/or paramedics within the community to fill identified health-care gaps. An initial stakeholder meeting was held with two more stakeholder meetings scheduled for spring 2014. Currently, models of reimbursement from other states are being studied.

4.2.8 Explore utilization of CHWs and/or Community Paramedic to assist individuals to improve or increase their capacity for self-management of chronic diseases including heart disease and stroke, cancer, diabetes and arthritis.
This is happening through the Community Paramedic project, referred to above.

4.2.8a Promote and support the use of lay health workers, following the model of American Indian Community Health Representatives and other models.

4.2.8b Encourage/revitalize community-based chronic disease programs.

4.2.8c Support the use of properly trained and culturally competent CHWs and/or Community Paramedics in communities that experience chronic disease care inequities.
This is happening through the Community Paramedic project, referred to above.

4.2.8d Promote use of pharmacists, dentists, case managers, CHWs, Community Paramedic and other health extenders to improve health outcomes.
- This is happening through the Community Paramedic project, referred to above.
- The NDSU pharmacy school partnered with the American Heart Association and NDDoH heart disease and stroke staff to discuss having pharmacists assist with the use of blood pressure control to help improve health outcomes.

4.3 Provide resources that encourage constructive self-management behaviors to the general population and friends and family members of people with chronic diseases.

Integration Activities:

4.3.1 Identify and communicate resources and tools for friends, family and co-workers that explain the fundamentals of the leading chronic diseases and tips for providing constructive and emotional support.

4.3.2 Educate patients on therapeutic lifestyle changes (TLC) to control and manage chronic disease and associated risk factors.

4.3.3 Connect friends and family to chronic disease support services in a variety of settings, such as schools, worksites, health-care facilities, and faith-based and community organizations.

4.3.4 Educate the public on the features and benefits of prevention, personal health behavior, self-management, survivorship and education services as a means to increase demand for services.

4.3.4a Conduct a statewide social marketing/media chronic disease campaign.

4.3.4aa Identify cross-cutting key messages.
NDDoH developed a chronic disease communication plan in December 2013 in a calendar format that includes health awareness days/weeks/months. The communication calendar will be used as a

tool for coordinating chronic disease communications and cross-promotion of programs and risk factors through press releases, social media, etc.

4.3.4ab Identify disease-specific messages (e.g., diabetes, heart disease, stroke, cancer, arthritis, asthma, tobacco control, obesity).

4.3.4b Consider the role that mental health, particularly depression, plays with chronic disease prevention and control, and link mental health with chronic disease in education opportunities.

HEALTH INEQUITIES

Goal 5: Address health inequities in planning for the improvement of population health.

Short Term Objectives:

By 2014, implement at least two policy or systems changes in organizations that relate to the collection/use of data and/or implementation of activities that address social determinants of health and chronic diseases.

By 2014, increase the knowledge of and ability to address social determinants of health for at least 75 key stakeholders across the state at the state and/or community level.

Strategies:

5.1 Ensure surveillance systems link social determinants of health to outcomes and behaviors across chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis.

Integration Activities:

5.1.1 Assess surveillance system capacity for measuring social determinants of health for analyzing health outcomes and health-related behaviors.

5.1.2 Collect social determinants of health indicators or link to other databases for analysis and incorporation into routine surveillance reporting and program planning.

5.1.2a Support efforts to improve the availability, accuracy and completeness of data collection in terms of race/ethnicity classification, third-party payers and other pertinent data components.

5.1.2b Determine potential data sources and disseminate chronic disease(s) health disparities data statewide to support chronic disease(s) control efforts.

5.2 Provide training and technical assistance to key stakeholders on the social determinants of health, including what they are and how to address them at the state and/or community level.

Integration Activities:

5.2.1 Provide technical assistance and educational opportunities to enhance and/or develop community-based and state-level projects that address social determinants of health for chronic disease prevention and management.

5.2.1a Promote and support ongoing cultural competency education opportunities and curricula training on social determinants of health, including strategies that health-care professionals can implement into practice to address and reduce inequities in chronic disease care, including but not limited to, gender, race or ethnicity, education, income or employment, refugee or immigrant status, age, geographic location, physical or mental status and sexual orientation or gender identity.
The Tobacco Prevention and Control Program worked with the Northern Plains Tribal Tobacco Technical Assistance Center to provide a training specific for Native populations on brief interventions to address tobacco use through the tribal community health representatives. This training was offered at all four North Dakota reservations.

5.2.1b Support the local development appropriate educational materials regarding social determinants of health utilizing community feedback surrounding the topic of chronic disease.

5.2.1c Support culturally competent and informed/shared decision-making tools regarding clinical trials, screening, treatment and survivorship.

5.2.1d Advocate for policies that address tobacco-related disparities.
The NDDoH Tobacco Prevention and Control Program is working with disparate populations, including LGBT and Native Amerian. Policy efforts include having a smoke-free PRIDE event in Fargo and tribal coordinators working on policies within their reservations.

5.2.1e Advocate for the development of outreach systems for the underserved and minority populations, such as patient navigation.

5.2.1f Support culturally-appropriate environments from prevention through survivorship, palliative and end-of-life care.

5.2.1g Support collaborative efforts of tribal communities with other state and local partners.

5.2.1h Advocate for facility practices that support the needs of ethnic or minority populations.

5.2.1i Support and engage communities, minority health community organizations and those with health disparities in identifying and solving access to care issues.
The NDDoH Comprehensive Cancer Prevention and Control Program collaborated with Tribal Health staff from the Fort Berthold reservation and nursing students from the Fort Berthold Community College to host a bone marrow donor drive that registered 13 new American Indian donors on the National Marrow Donor Registry.

5.2.1k Support initiatives grounded in the unique historical and cultural contexts of communities and promote clinical, community and workplace prevention efforts that consider language, culture, age, preferred and accessible communication channels and health literacy skills for information that encourages adoption of healthy behaviors.

5.2.1l Support access to treatment medication for those who are medically underserved.

5.2.2 Support efforts to provide funding resources for the treatment and associated cost for the uninsured, underinsured and medically underserved populations.

5.2.2a Inform stakeholders about the prevalence and incidence of chronic diseases such as heart disease, cancer, stroke, diabetes and arthritis and related risk factors in terms of health inequities and social determinants of health.

5.2.2b Use the PBS Unnatural Causes Series to educate coalition members and local community leaders/organizations about social determinants of health and how to use that information to effectively prevent and control chronic disease for disparate populations.

5.2.2c Support activities that provide culturally competent treatment, such as appropriate environments for treatment and educational material.
The NDDoH Tobacco Prevention and Control Program worked with staff at Migrant Health to revise the Spanish language NDQuits materials.

5.2.2d Support efforts to increase the number of racial and ethnic minority individuals in the health-care field, including supporting education regarding the career opportunities available.

5.2.2e Promote access to culturally-appropriate health care and culturally-sensitive health materials.
The NDDoH Tobacco Prevention and Control Program created and distributed palm cards to each reservation that highlight topics such as quitting tobacco, using NDQuits and traditional versus commercial tobacco use.

CAPACITY

Goal 6: Develop capacity (including leadership, management, training, resources and partnerships) to advance chronic disease prevention and health promotion in N.D.

Short Term Objectives:

By 2014, increase from 12 to 18 the number of partners coordinating and collaborating on chronic disease prevention and health promotion activities in the state plan.
Currently there are about 50 partners on the Coordinated Chronic Disease Partnership.

By 2014, develop at least five capacity-building resources/tools/systems to ensure state-level capacity is in place to advance chronic disease prevention and health promotion in N.D.

Strategies:

6.1 Establish the NDDoH's CCDPP Coordination Team with at least 10 team members and define operational and collaborative processes for the CCDP Coordination Team that will enhance coordination, improve efficiencies, provide a forum for sharing best practices and eliminate redundancies across multiple chronic disease-related program areas at the NDDoH.

Integration Activities:

6.1.1 Provide leadership and an environment that supports collaboration and coordination of efforts.
The NDDoH has an internal team called the Chronic Disease Coordination Team (CDCT) that consists of various NDDoH program staff, evaluators, and an epidemiologist who work on chronic disease prevention and control activities. This group meets monthly to discuss opportunities for collaborating on NDDoH chronic disease projects and implementing the chronic disease state plan in conjunction with the Coordinated Chronic Disease Partnership.

6.1.2 Integrate work plans with other chronic disease state program work plans.
NDDoH chronic disease staff members have worked to integrate the chronic disease state plan with other state plans, such as the MCH-Title V state plan.

6.1.3 Create a report and/or diagram of overlapping goals/activities between organizations and communities. Consider ways to integrate common activities to maximize resources and coordinate efforts.

6.1.4 Develop an organizational identity for the CCDPP and its governing body (partnership) to help build the program into a recognized movement that promotes the importance of chronic disease prevention; provides leadership in communicating the need for policy and environmental changes that support healthy eating and active lifestyles; and demonstrates knowledge in evidence-based strategies to prevent, treat and control chronic disease and its related risk factors.

6.1.5 Sponsor or jointly plan local, regional and statewide trainings, conferences and technical assistance on best practices for effective chronic disease prevention

strategies for work sites, schools, tribal communities, public health, health organizations, health plans, employers and others.
On May 20-21, 2013, NDDoH held its first Chronic Disease State Conference titled "Working Together: Preventing and Managing Chronic Disease in North Dakota." The conference brought together 160 health professionals from across the state.

6.2 Apply for funding and leverage resources for planning, implementing and evaluating chronic disease prevention and health promotion efforts.

Integration Activities:

6.2.1 Develop and offer a training opportunity for local partners on where to seek chronic disease funding opportunities and how to apply for grants (grant writing 101).

6.2.2 Secure and protect public funding and state appropriations that support chronic disease programs and other public health initiatives targeted at chronic disease, related risk factors and the disparities that exist in these areas.
During the 2013 Legislative Session, additional dollars for the Stroke System of Care were secured. The tobacco prevention and control funding also remained intact.

6.2.3 Explore opportunities to generate and direct additional fiscal resources for chronic disease programming/initiatives and support efforts to leverage new and existing federal funds and grants to implement state plan objectives and strategies.

6.3 Develop infrastructure building plans that build capacity across the state for chronic disease prevention and health promotion.

Integration Activities:

6.3.1 Develop and implement a staffing and training plan to support a coordinated and collaborative approach to chronic disease prevention and health promotion with an emphasis on public health policy, environmental improvements and effective chronic disease prevention and management.

6.3.2 Develop and implement a communication plan to inform the public and stakeholders about chronic disease prevention and health promotion burden, interventions and impact.

6.3.2a Develop a communication plan that assists in framing messages, presentations and materials to support implementation of the state plan and communicates the importance and urgency of addressing chronic disease.
NDDoH developed a chronic disease communication plan in December 2013 in a calendar format that includes health awareness days/weeks/months. The communication calendar will be used as a tool for coordinating chronic disease communications and cross-promotion of programs and risk factors through press releases, social media, etc.

6.3.3 Develop and implement a plan that describes how chronic disease prevention and health promotion policies will be developed collaboratively with partners and used to increase the number, reach, quality and impact of statewide, local and organizational policies to support health and healthy behaviors.

6.4 Implement opportunities that direct collaborative resources for programs and initiatives that support chronic disease prevention and health promotion efforts.

Integration Activities:

6.4.1 Explore coordination and integration of state health department community-based grant programs.

6.4.2 Engage and/or link with partners to identify ways to implement a coordinated chronic disease and health promotion approach for underserved or underrepresented populations as it specifically relates to the NDDoH.

6.4.3 Provide action plan training on goal, objective, strategy development and program evaluation.